

ATTACHMENT 6

Sample CMS 1500 claim form for outpatient mental health and substance abuse services in the home or community — county owned clinics (not a "biller only" provider)

HEALTH INSURANCE CLAIM FORM										PICA	
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 1234567890	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Recipient, Im A.				3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input checked="" type="checkbox"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
5. PATIENT'S ADDRESS (No., Street) 609 Willow St				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)					
CITY Anytown		STATE WI		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		CITY		STATE			
ZIP CODE 55555		TELEPHONE (Include Area Code) (XXX) XXX-XXXX		Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>		ZIP CODE		TELEPHONE (INCLUDE AREA CODE)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) OI-P				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/> b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY					
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE I.M. Referring/Prescribing				17a. I.D. NUMBER OF REFERRING PHYSICIAN 12345678		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 290 3. _____ 2. _____ 4. _____				23. PRIOR AUTHORIZATION NUMBER		24. A DATE(S) OF SERVICE. To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE 1 12 08 03 12 90801 UA UC 1 XX XX 1.0 2 12 15 03 12 90806 UA UC 1 XX XX 1.0 3 12 22 03 29 12 90857 HO UC 1 XX XX 2.0 4 5 6					
25. FEDERAL TAX I.D. NUMBER SSN EIN		26. PATIENT'S ACCOUNT NO. 1234JED		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ XXX XX		29. AMOUNT PAID \$ XX XX		30. BALANCE DUE \$ XX XX	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) I.M. Provider MM/DD/YY SIGNED _____ DATE _____				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # I.M. Billing 1 W. Williams PIN# _____ GRP# _____					

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

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